



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GRACE MEDICAL CENTER
2412 50TH STREET
LUBBOCK TX 79412

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-3680-01

MFDR Date Received

August 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Injured worker presented himself at our facility for care, and was given such care, we feel that we should be fully compensated for the care that was given."

Amount in Dispute: \$719.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the requestor's documentation does not substantiate a medical emergency."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2012	Outpatient Hospital Services	\$719.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 26, 2012

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Explanation of benefits dated August 7, 2012

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

Findings

1. The insurance carrier denied disputed services with reason code, 899 – “DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2”. 28 Texas Administrative Code §133.2(4)(A) states that, “a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” For example:
 - a. INITIAL NURSING ASSESMENT, page 4 of 4 “General Appearance, No Distress”
 - b. History of Present Illness, Severity: “moderate”

The Division concludes the denial code 899 is supported.

2. Submitted documentation pursuant to 28 TAC §133.2(4)(A) does not support payment of disputed services.
3. The Division cannot recommend payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		April 26, 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.